NHS

Leeds Community Healthcare

# The Community Matron Role

# Community Matrons???

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# ? Community Matron

"A Community Matron is a nurse who provides advanced clinical nursing care in addition to case management to an identified group of very high intensity users through case finding"

DH 2005

# Historical perspective (1)

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- Introduced in 2004 in response to NHS Improvement Plan.
- Term ‘Community Matron’ in response to Government public listening exercise
- Patients with LTC are more likely to see their GP, be admitted to hospital, and stay longer in hospital than those without LTC.

# Historical perspective (2)

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- CM's described in document as experienced, skilled nurses using case management techniques.

- Aim- to work with VHIU to reduce hospital admissions, prevent unnecessary admissions.

# Kaiser Permanente triangle

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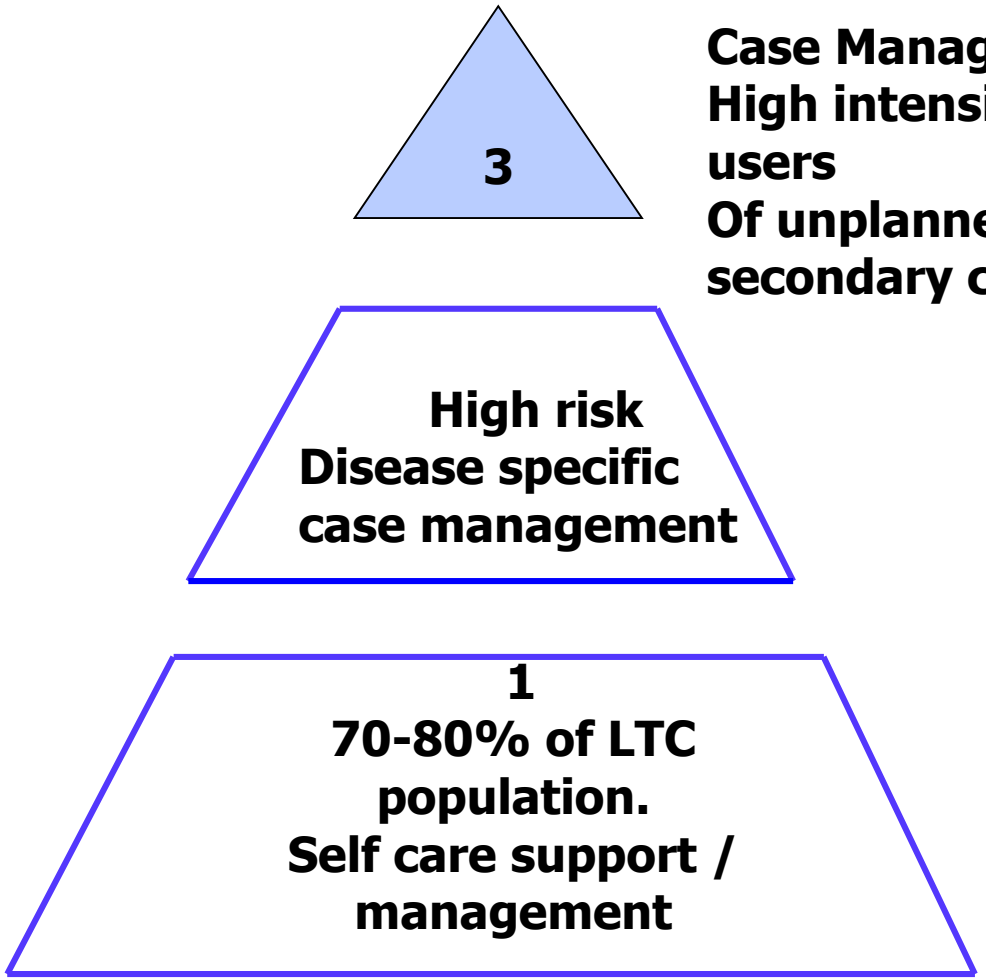

# Case Management

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**"Need to be proactive and co-ordinated in identifying the most complex and vulnerable people with a long term condition and then co-ordinating and managing their care in partnership with the individual and their carers"**

DH 2005

# Community Matrons

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- Identify patients at risk of unplanned admission to hospital
- Enable each patient to have a personalised and emergency care plan based on their needs
- Work in partnership with Doctors, Social Services and the Voluntary sector

# Patient Identification

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- Risk Stratification
- GP referral
- Specialist Nurse
- District Nurse referral
- Consultant referral
- Hospital referral
- Intermediate Tier Service Referral
- Social Services Referral

# The Aim Of The Role

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- Earlier detection of problems/illness
- Diagnose, initiate tests, treat, prescribe and plan care
- Good control of symptoms
- More effective medicine management
- Reduction in number of crises
- Promotion of independence
- Improving the quality of life
- Improve/manage mental wellbeing
- End of life care for LTCs

# Competencies

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- Advanced Clinical Nursing practice
- Independent Prescribing
- Leading Complex Care Co-ordination
- Proactively Manage Complex long term Conditions
- Managing Cognitive Impairment & Mental Well Being
- Supporting Self Care, Self Management and Enabling Independence
- Professional Practice and Leadership
- Identifying High Risk People, Promoting Health and Preventing Ill Health

# Case Study 1

- Male aged 63 married 1 son
- PMH COPD RA OA
- Prior to CM service 8 admissions, GP home visits 17
- Interventions
- 12 months matron input: hospital admissions and GP home visits reduced

# Case Study 2

- Male 47 wife two children
- Ehlers-danlos syndrome osteogenesis imperfecta copd chronic pain
- Recurrent admissions prolonged stays
- Multiple professionals involved
- strategies

# What matters most?
# A case study!

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- 92 year old male lives alone
- Son who has mental health problems daughter lives in Scotland.
- COPD Type II diabetes Heart Failure
- Recurrent admissions to secondary care and GP call outs

- Talk in groups what questions would you ask, what will you be assessing, what actions will you take e.g observations ?

# Problems identified :-

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- Falls due to feeling light headed and hypotension
- Medications and inhalers all over house
- Ulcer to left leg dry skin
- Home care 1 x per day
- Urinary frequency and smells
- Poor nutrition
- Poor diabetic control
- Shortness of breath
- Frequent admissions
- ACTION PLAN OVER TO YOU !!

# Community Matron Activity (1)

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- Lying standing BP
- Bloods
- Medication Review and refer to medicines management
- Check latest discharge letter
- Refer to integrated team including social worker and DN
- Dip urine
- Weight and nutritional assessment
- Pressure ulcer risk screening
- Inhaler technique.

# Community Matron Activity (2)

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**Advanced clinical assessment**

**Enter information on clinical records**

**Refer for telehealth**

**Emergency Care plan**

**Discuss emergency rescue medication i.e. steroids and antibiotics.**

**Systematic intervention and prescribing for associated problems e.g. UTI**

**Reduced diuretic**

**Optimised inhaler treatment**

**Using compliance aid**

**Education re symptom recognition**

**Telecare installed.**

Social work assessment includes increased care package  meals on wheels for lunch and evening visit from home care, flask left at each visit.

DN 2 x weekly to dress leg.

# Outcomes

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- Alternate weekly visits from CM to monitor health.
- Understands Community Matron service, appropriate use and access. Calls service for advice/visit when exacerbating
- Hospital admission – none for 8months
- No GP call outs
- Weight stable
- Diabetic control improved
- Wound healed

# Next Steps

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## Advanced Care Planning

# Key challenges

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- Continuing development of workforce
- Continuing education, competencies
- Supervision and mentorship
- Adoption of optimal case finding tool.
- Improving integration with social services, voluntary sector
- Speed up availability of care to prevent admissions

# The road ahead!

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- Integrated working
- Showcasing services
- Working closely with Practice Based Commissioners
- Leadership
- Developing Service Model
- New ways of working

# References

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- DH (2004) NHS Improvement Plan
- DH (2005a) Supporting people with Long Term Conditions: Liberating the talents of nurses who care for people with LTC.
- DH (2005b)Case management competencies framework for the care of people with LTC.
- DH (2005) NSF for LTC
- DH (2008) High Quality Care For All. NHS Next Stage review Final report